REFERENCE FORM

Name of Applicant: _____

Referee: Name and Position _____

Hospital Name/Location _____

This evaluation should be based on demonstrated performance compared to that reasonably expected of a physician with similar level of training, experience and background as the applicant. Please complete all parts of this form.

Referee Information:

i. Is the applicant related to you? ☐ Yes ☐ No

ii. Are you in a position of formal authority over the applicant's work? ☐ Yes ☐ No

iii. In what capacity have you worked with the applicant? (i.e. Chief of Staff, Program Director, Colleague, Nurse, etc.) _____

iv. How long have you worked with the applicant? _____

v. Where have you worked with the applicant? _____

Candidate Information:

I. Clinical Practice

Description of the candidate's medical activities:

_____

_____

_____

	Superior	Fully Satisfactory	Satisfactory	Not Satisfactory	Unknown
Clinical knowledge					
Clinical competence					
Professional judgment					
Technical skills					
Problem solving ability					
Discharge planning					
Overall performance					

Comments:_____

_____

II. Resource Utilization, and Administrative Duties

	Above Average	Average	Below Average
Utilization of diagnostic and therapeutic agents			
Timeliness of medical record completion			
Quality of medical record documentation			
Prepares written documentation (e.g. patient notes, discharge summaries and patient letters) that are accurate, organized and timely			
On-call dependability			
Participates in administration and leadership roles, as appropriate			
Attendance at meetings/Committee participation			

Comments:_____

_____

III. Professional Attitude / Interpersonal Skills

	Above Average	Average	Below Average
Oral communication skills			
Participate effectively and appropriately in an interprofessional health care team			
Establishes a therapeutic relationship and communicates well with patients and families			
Relationship with other physicians			
Relationship with nursing staff			
Demonstrates integrity, honesty, compassion and respect for others			
Professional behavior (attitude/emotional stability)			

Comments:_____

_____

IV. Continuing Professional Development

	Above Average	Average	Below Average	Unknown
Participation in educational activities				
Demonstrates lifelong learning skills				
Aware of own limitations; seeks assistance and/or feedback; and accepts advice graciously				

Comments: _____

_____

V. Strengths/Areas of Improvement

What are the applicant's greatest strengths?

_____

_____

_____

What areas of improvement and development have been identified for the applicant?

_____

_____

_____

VI. Have you any additional information with respect to this applicant which may be relevant to his/her application for registration to practice medicine in Ontario?

_____

_____

_____

VII. Summary Recommendation (Please choose the most appropriate statement)

Recommend without reservation ☐

Recommend with reservations (please explain below) ☐

Do not recommend (please explain below) ☐

Please call me to discuss this applicant Yes ☐ No ☐

Phone number and the best time to contact you: _____

Comments/Reservations:

_____

_____

Print Name: _____ Title: _____

Signature: _____ Date: _____

Please mail completed form directly to the College, not to the applicant:

Registration Department
College of Physicians and Surgeons of Ontario
80 College Street
Toronto, ON M5G 2E2

Completed form may also be faxed to the Registration Department at **(416) 967-2623**. If faxing, be sure to include a covering page clearly indicating the source.

If you have any questions, please contact the Inquires Section in the Registration Department at (416) 967-2617.

Thank you. We appreciate the time you took to complete this document.

Rev. Nov. 1, 2011